1.0 Description of Service

The covered services described below are assessments and treatments provided to Medicaid-eligible children through a child's Individualized Education Program (IEP) and performed by school staff or contracted personnel. It is the responsibility of the LEA to ensure that clinicians, including contractors, are appropriately credentialed.

1.1 Audiology Services

Assessment

Service may include testing and/or clinical observation as appropriate for chronological or developmental age for one or more of the following areas of functioning, and shall yield a written report.

- auditory sensitivity, including pure tone air and bone conduction, speech detection, and speech reception thresholds
- auditory discrimination in quiet and noise
- impedance audiometry, including tympanometry and acoustic reflex
- hearing aid evaluation
- central auditory function
- auditory brainstem evoked response

Treatment

Service may include one or more of the following as appropriate:

- auditory training
- speech reading
- augmentative communication

1.2 Speech/Language Services

Assessment

Service may include testing and/or clinical observation as appropriate for chronological or developmental age for **all** the following areas of functioning and shall yield a written report.

- receptive and expressive language
- auditory memory, discrimination, and processing
- vocal quality and resonance patterns
- phonological development
- pragmatic language
- rhythm/fluency
- oral mechanism
- swallowing assessment
- augmentative communication
- hearing status based on pass/fail criteria

Treatment
Service includes one or more of the following as appropriate:

- articulation therapy
- language therapy; receptive and expressive language
- augmentative communication training
- auditory processing, discrimination, and training
- fluency training
- disorders of speech flow
- voice therapy
- oral motor training; swallowing therapy
- speech reading

1.3 Occupational Therapy Services

Assessment
Service may include testing and/or clinical observation as appropriate for chronological or developmental age for one or more of the following areas of functioning, and shall yield a written report.

- activities of daily living assessment
- sensorimotor assessment
- neuromuscular assessment
- fine motor assessment
- feeding/oral motor assessment
- visual perceptual assessment
- perceptual motor development assessment
- musculo-skeletal assessment
- gross motor assessment
- functional mobility assessment
- pre-vocational assessment

Treatment
Service may include one or more of the following as appropriate:

- activities of daily living training
- sensory integration
- neuromuscular development
- muscle strengthening, endurance training
- feeding/oral motor training
- adaptive equipment application
- visual perceptual training
- facilitation of gross motor skills
- facilitation of fine motor skills

- fabrication and application of splinting and orthotic devices
- manual therapy techniques
- sensorimotor training
- pre-vocational training
- functional mobility training
- perceptual motor training

1.4 Physical Therapy Services

Assessment

Service may include testing and/or clinical observation as appropriate for chronological or developmental age for one or more of the following areas of functioning, and shall yield a written report.

- neuromotor assessment
- range of motion, joint integrity and functional mobility, flexibility assessment
- gait, balance, and coordination assessment
- posture and body mechanics assessment
- soft tissue assessment
- pain assessment
- cranial nerve assessment
- clinical electromyographic assessment
- nerve conduction, latency and velocity assessment
- manual muscle test
- activities of daily living assessment
- cardiac assessment
- pulmonary assessment
- sensory motor assessment
- feeding/oral motor assessment

Treatment

Service may include one or more of the following as appropriate:

- manual therapy techniques
- fabrication and application of orthotic devices
- therapeutic exercise
- functional training
- facilitation of motor milestones
- sensory motor training
- cardiac training
- pulmonary enhancement
- adaptive equipment application
- feeding/oral motor training

- activities of daily living training
- gait training
- posture and body mechanics training
- muscle strengthening
- gross motor development
- modalities
- therapeutic procedures
- hydrotherapy
- manual manipulation

1.5 Psychological/Counseling Services

Assessment

Service may include testing and/or clinical observation as appropriate for chronological or developmental age for one or more of the following areas of functioning, and shall yield a written report.

- cognitive
- emotional/personality
- adaptive behavior
- behavior
- perceptual or visual motor

Treatment

Service may include one or more of the following as appropriate:

- cognitive-behavioral therapy
- rational-emotive therapy
- family therapy
- individual interactive psychotherapy using play equipment, physical devices, language interpreter or other mechanisms of non verbal communication and sensory integrative therapy
- sensory integrative therapy

2.0 Eligible Recipient

2.1 General Provisions

Medicaid recipients may have service restrictions due to their eligibility category that would make them ineligible for this service.

2.2 Limitations

Recipients ages 3 years through 20 years who are enrolled in a public school are eligible. Recipient eligibility for health-related services depends upon whether:

- the recipient is Medicaid-eligible when services are provided
- the recipient's need for treatment services has been confirmed by a licensed physician, physician assistant or nurse practitioner
- the recipient receives the service(s) in the public school setting or a setting identified in an Individualized Education Plan (IEP) or Individualized Family Service Plan (IFSP) and is receiving special education services as part of an IEP/IFSP

2.3 Special Provisions

Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) is a federal Medicaid requirement that provides recipients under the age of 21 with medically necessary health care to correct or ameliorate a defect, physical or mental illness or a condition identified through a screening examination. While there is no requirement that the service, product or procedure be included in the State Medicaid Plan, it must be listed in the federal law at 42 U.S.C. § 1396d(a). Service limitations on scope, amount or frequency described in this coverage policy do not apply if the product, service or procedure is medically necessary.

The Division of Medical Assistance's policy instructions pertaining to EPSDT are available online at http://www.dhhs.state.nc.us/dma/prov.htm.

3.0 When Service is Covered

Service is covered when it is medically necessary and is outlined in an IEP/IFSP.

3.1 Physical Therapy (PT)

Medicaid accepts the medical necessity criteria for beginning, continuing, and terminating treatment as published by the American Physical Therapy Association in the most recent edition of *Physical Therapy: Guide to Physical Therapist Practice, Part Two: Preferred Practice Patterns.*

Exception: A specific "treatable" functional impairment that impedes ability to participate in productive activities needs to be identified as the basis for beginning treatment rather than a specific "reversible" functional impairment that impedes ability to participate in productive activities.

3.2 Occupational Therapy (OT)

Medicaid accepts the medical necessity criteria for beginning, continuing, and terminating treatment as published by the American Occupational Therapy Association in the most recent edition of *Occupational Therapy Practice Guidelines Series.*

Exception: A specific "treatable" functional impairment that impedes ability to participate in productive activities needs to be identified as the basis for beginning treatment rather than a specific "reversible" functional impairment that impedes ability to participate in productive activities.

3.3 Speech/Language-Audiology Therapy

Medicaid accepts the medical necessity criteria for Speech/Language-Audiology therapy treatment as follows:

- *Basic Elements of Coverage of Speech-Language Pathology and Dysphagia Services* (http://cms.hhs.gov/manuals/pub13/pub_13.asp)- Section 3101.10A) **and**
- *Special Instructions for Medical Review of Dysphagia Claims* (http://cms.hhs.gov/manuals/108_pim/pim83c06s07.asp#Sect10) **and**
- The following criteria for *Birth to 21 Years*:

Language Impairment Classifications Infant/Toddler – Birth to 3 Years	
Mild	• Standard scores 1 to 1.5 standard deviations below the mean, **or** • Scores in the 7th –15th percentile, **or** • A language quotient or standard score of 78 – 85, **or** • A 20% - 24% delay on instruments that determine scores in months, **or** • Additional documentation of examples indicating that the child exhibits functional impairment in one or more of the following language components: syntax, morphology, semantics or pragmatics.
Moderate	• Standard scores 1.5 to 2 standard deviations below the mean, **or** • Scores in the 2nd – 6th percentile, **or** • A language quotient or standard score of 70 – 77, **or** • A 25% - 29% delay on instruments which determine scores in months, **or** • Additional documentation of examples indicating that the child exhibits functional impairment in one or more of the following language components: syntax, morphology, semantics or pragmatics.
Severe	• Standard scores more than 2 standard deviations below the mean, **or** • Scores below the 2nd percentile, **or** • A language quotient or standard score of 69 or **lower**, **or** • A 30% or more delay on instruments that determine scores in months, **or** • Additional documentation of examples indicating that the child exhibits functional impairment in one or more of the following language components: syntax, morphology, semantics or pragmatics.

Preschool – Age 3 Years to Kindergarten-Eligible Language Impairment Classifications	
Mild	• Standard scores 1 to 1.5 standard deviations below the mean, **or** • Scores in the 7^{th} – 15^{th} percentile, **or** • A language quotient or standard score of 78 – 85, **or** • If standard scores are not obtainable or are deemed unreliable, information gathered from checklists, observations, etc. that demonstrates a 6 to 12 month delay, **or** • Additional documentation of examples indicating that the child exhibits functional impairment in one or more of the following language components: syntax, morphology, semantics or pragmatics.
Moderate	• Standard scores 1.5 to 2 standard deviations below the mean, **or** • Scores in the 2^{nd} – 6^{th} percentile, **or** • A language quotient or standard score of 70 – 77, **or** • If standard scores are not obtainable or are deemed unreliable, information gathered from checklists, observations, etc. that demonstrates a 13 to 18 month delay, **or** • Additional documentation of examples indicating that the child exhibits functional impairment in one or more of the following language components: syntax, morphology, semantics or pragmatics.
Severe	• Standard scores more than 2 standard deviations below the mean, **or** • Scores below the 2^{nd} percentile, **or** • A language quotient or standard score of 69 or lower, **or** • If standard scores are not obtainable or are deemed unreliable, information gathered from checklists, observations, etc. that demonstrates a 19 month or more delay, **or** • Additional documentation of examples indicating that the child exhibits functional impairment in one or more of the following language components: syntax, morphology, semantics or pragmatics.

Language Impairment Classifications School Age – Kindergarten-Eligible to Age 21	
Mild	• Standard scores 1 to 1.5 standard deviations below the mean, **or** • Scores in the 7^{th} – 15^{th} percentile, **or** • A language quotient or standard score of 78 –85, **or** • If standard scores are not obtainable or are deemed unreliable, information gathered from checklists, observations, etc. that demonstrate a 1-year to 1-year, 6-month delay, **or** • Additional documentation of examples indicating that the child exhibits functional impairment in one or more of the following language components: syntax, morphology, semantics, or pragmatics.
Moderate	• Standard scores 1.5 to 2 standard deviations below the mean, **or** • Scores in the 2^{nd} – 6^{th} percentile, **or** • A language quotient or standard score of 70 – 77, **or** • If standard scores are not obtainable or are deemed unreliable, information gathered from checklists, observations, etc. that demonstrates a 1-year, 7-month to 2-year delay, **or** • Additional documentation of examples indicating that the child exhibits functional impairment in one or more of the following language components: syntax, morphology, semantics or pragmatics.
Severe	• Standard scores more than 2 standard deviations below the mean, **or** • Scores below the 2^{nd} percentile, **or** • A language quotient or standard score of 69 or lower, **or** • If standard scores are not obtainable or are deemed unreliable, information gathered from checklists, observations, etc. that demonstrates a 2-year or more delay, **or** • Additional documentation of examples indicating that the child exhibits functional impairment in one or more of the following language components: syntax, morphology, semantics or pragmatics.

Articulation/Phonology Impairment Classifications All Ages	
Mild	• Standard scores 1 to1.5 standard deviations below the mean, **or** • Scores in the 7^{th} – 15^{th} percentile, **or** • One phonological process that is not developmentally appropriate, with a 20% occurrence, **or** • Additional documentation of examples indicating a delay, such as percent consonant correct measures, measures of intelligibility, tests of stimulability, etc. Child is expected to have few articulation errors, generally characterized by typical substitutions, omissions, and/or distortions. Intelligibility not greatly affected but errors are noticeable.
Moderate	• Standard scores 1.5 to 2 standard deviations below the mean, **or** • Scores in the 2^{nd} – 6^{th} percentile, **or** • Two or more phonological processes that are not developmentally appropriate, with a 20% occurrence, **or** • At least one phonological process that is not developmentally appropriate, with a 21% - 40% occurrence, **or** • Additional documentation of examples indicating a delay, such as percent consonant correct measures, measures of intelligibility, tests of stimulability, etc. Child typically has 3 to 5 sounds in error, which are one year below expected development. Error patterns may be atypical. Intelligibility is affected and conversational speech is occasionally unintelligible.
Severe	• Standard scores more than 2 standard deviations below the mean, **or** • Scores below the 2^{nd} percentile, **or** • Three or more phonological processes that are not developmentally appropriate, with a 20% occurrence, **or** • At least one phonological process that is not developmentally appropriate, with more than 40% occurrence, **or** • Additional documentation of examples indicating a delay, such as percent consonant correct measures, measures of intelligibility, tests of stimulability, etc. Child typically has more than five sounds in error with a combination of error types. Inconsistent errors and lack of stimulability is evident. Conversational speech is generally unintelligible.

Articulation Treatment Goals Based on Age of Acquisition	
Age of Acquisition	**Treatment Goal(s)**
Before Age 2	Vowel sounds
After Age 2, 0 months	/m/, /n/, /h/, /w/, /p/, /b/
After Age 3, 0 months	/f/, /k/, /g/, /t/, /d/
After Age 4, 0 months	/n/, /j/
After Age 5, 0 months	voiced th, sh, ch, /l/, /v/, j
After Age 6, 0 months	/s/, /r/, /z/, /s/ blends, /r/ blends, vowelized /r/, voiceless th, /l/ blends
In using these guidelines for determining eligibility, total number of errors and intelligibility should be considered. A 90% criterion is roughly in accord with accepted educational and psychometric practice that considers only the lowest 5% - 10% of performances on a standardized instrument to be outside the normal range.	

Phonology Treatment Goals Based on Age of Acquisition of Adult Phonological Rules	
Age of Acquisition	**Treatment Goal(s)**
After age 2 years, 0 months	Syllable reduplication
After age 2 years, 6 months	Backing, deletion of initial consonants, metathesis, labialization, assimilation
After age 3 years, 0 months	Final consonant devoicing, fronting of palatals and velars, final consonant deletion, weak syllable deletion /syllable reduction, stridency deletion/ stopping, prevocalic voicing, epenthesis
When children develop idiosyncratic patterns, which exist after age 3 years, 0 months to 3 years, 5 months, they likely reflect a phonological disorder and should be addressed in therapy. Minor processes, or secondary patterns such as glottal replacement, apicalization and palatalization typically occur in conjunction with other major processes. These minor processes frequently correct on their own as those major processes are being targeted.	
After age 4 years, 0 months	Deaffrication, vowelization/vocalization, cluster reduction, gliding

Eligibility Guidelines for Stuttering	
Borderline/Mild	3 – 10 sw/m or 3% - 10% stuttered words of words spoken, provided that prolongations are less than 2 seconds and no struggle behaviors and that the number of prolongations does not exceed total whole-word and part-word repetitions.
Moderate	More than 10 sw/m or 10% stuttered words of words spoken, duration of dysfluencies up to 2 seconds; secondary characteristics may be present.
Severe	More than 10 sw/m or 10% stuttered words of words spoken, duration of dysfluencies lasting 3 or more seconds, secondary characteristics are conspicuous.
Note: When the percentage of stuttered words fall in a lower severity rating and duration and/or presence of physical characteristics falls in a higher severity rating, the service delivery may be raised to the higher level.	

Differential Diagnosis for Stuttering

Characteristics of normally dysfluent children:

- Nine dysfluencies or less per every 100 words spoken.
- Majority types of dysfluencies include: whole-word, phrase repetitions, interjections, and revisions.
- No more than two unit repetitions per part-word repetition (e.g., b-b-ball, but not b-b-b ball.).
- Schwa is not perceived (e.g., bee-bee-beet. is common, but not buh-buh-buh-beet).
- Little if any difficulty in starting and sustaining voicing; voicing or airflow between units is generally continuous; dysfluencies are brief and effortless.

Differential Diagnosis for Stuttering
The following information may be helpful in monitoring children for fluency disorders. This information indicates dysfluencies that are considered typical in children, crossover behaviors that may be early indicators of true stuttering and what characteristics are typical of true stutterers. More Usual (Typical Dysfluencies) • Silent pauses; interjections of sounds, syllables or words; revisions of phrases or sentences; monosyllabic word repetitions or syllable repetitions with relatively even rhythm and stress; three or less repetitions per instance; phrase repetitions. Crossover Behaviors • Monosyllabic word repetitions or syllable repetitions with relatively even stress and rhythm but four or more repetitions per instance, monosyllabic word repetitions or syllable repetitions with relatively uneven rhythm and stress with two or more repetitions per instance. More Unusual (Atypical Dysfluencies) • Syllable repetitions ending in prolongations; sound, syllable or word prolongations; or prolongations ending in fixed postures of speech mechanism, increased tension noted in the act.

- **Augmentative and Alternative Communication** (AAC) standards for treatment from ASHA *Augmentative Communication Strategies*, volume II, 1988:

Note:

1. These criteria define parameters for involvement and services of the therapist for evaluation and treatment, not purchases of the devices or equipment.
2. These criteria are not intended to override or replace existing limits on coverage for services, either as dollar amounts or as acceptable billing codes.

"The primary purpose of an augmentative communication program is to enhance the quality of life for persons with severe speech and language impairments in accordance with each person's preferences, abilities, and life style. Augmentative communication programs perform the continuing, vital, and unique task of helping these individuals develop communication skills they will need throughout the course of their lives. The programs also encourage the development of each individual's initiative, independence, and sense of personal responsibility and self-worth."

AAC treatment programs are developed in accordance with Preferred Practices approved by ASHA. These services include:

- Counseling
- Product Dispensing
- Product Repair/Modification
- AAC System and/or Device Treatment/Orientation
- Prosthetic/Adaptive Device Treatment/Orientation
- Speech/Language Instruction

AAC treatment codes are used for the following:

- Therapeutic intervention for device programming and development
- Intervention with family members/caregivers/support workers, and individual for functional use of the device
- Therapeutic intervention with the individual in discourse with communication partner using his/her device

The above areas of treatment need to be performed by a licensed Speech-Language Pathologist with education and experience in augmentative communication to provide therapeutic intervention to help individuals communicate effectively using their device in all areas pertinent to the individual. Treatment will be authorized when the results of an authorized AAC assessment recommend either a low-tech or a high-tech system.

Any time the individual's communication needs change for medical reasons, additional treatment sessions should be requested. In addition, if an individual's device no longer meets his/her communication needs, additional treatment sessions should be requested.

Possible reasons to request authorization for additional treatment include:

- Update of device
- Replacement of current device
- Significant revisions to the device and/or vocabulary
- Medical changes

3.3.1 Audiology Therapy (Aural Rehabilitation) Practice Guidelines

The basis for audiology referral is the presence of any degree or type of hearing loss on the basis of the results of an audiologic (aural) rehabilitation assessment or presence of impaired or compromised auditory processing abilities on the basis of the results of a central auditory test battery.

Examples of deficits for initiating therapy may include, **but are not limited to**, the following:

- Hearing loss (any type) >25 dBHL at 2 or more frequencies in either ear
- Standard Score more than 1 SD (standard deviation) below normal for chronological age on standardized tests of language, audition, speech, or auditory processing
- Impaired or compromised auditory processing abilities as documented on the basis of the results of a central auditory test battery
- Less than 1-year gain in skills (auditory, language, speech, processing) during a 12-month period of time

Underlying Referral Premise
Aural rehabilitation will:

1. facilitate receptive and expressive communication of individuals with hearing loss, and/or,
2. achieve improved, augmented or compensated communication processes, and/or,
3. improve auditory processing, listening, spoken language processing, overall communication process, and/or,
4. benefit learning and daily activities.

Evaluation – Audiologic (Aural) Rehabilitation
Service delivery requires the following elements:

Note: Functioning of hearing aids, assistive listening systems/devices, and sensory aids must be checked prior to the assessment.

Through interview, observation, and clinical testing, evaluate (in both clinical and natural environments):

- Client history
- Reception, comprehension, and production of language in oral, signed or written modalities
- Speech and voice production
- Perception of speech and non-speech stimuli in multiple modalities
- Listening skills
- Speech reading
- Communication strategies

Include the ICD-9-CM diagnosis code. Determine specific functional limitation(s) (must be measurable) for client.

Evaluation – Central Auditory Processing Disorders (CAPD)

Note: CAPD assessment is to be interdisciplinary (involving audiologist, speech/language pathologist, and neuropsychologist) and is to include tests to evaluate the overall communication behavior, including spoken language processing and production, and educational achievement of individuals.

Through interview, observation, and clinical testing, evaluate:

- Communication, medical, educational history.
- Central auditory behavioral tests. Types of central auditory behavioral tests include:
  - Tests of temporal processes
  - Tests of dichotic listening
  - Low redundancy monaural speech tests
  - Tests of binaural interaction
- Central auditory electrophysiologic tests include:
  - Auditory brainstem response (ABR)
  - Middle latency evoked response (MLR)
  - N1 and P2 (late potentials) responses and P300
  - Mismatched negativity (MMN)
  - Middle ear reflex
  - Crossed suppression of otoacoustic emissions

Interpretations are derived from multiple tests based on age-appropriate norms. Evaluation may involve a series of tests given over a period of time at one or more clinic appointments. Procedures in a CAPD battery should be viewed as separate entities for purposes of service provision and reimbursement

Include the ICD-9-CM diagnosis code. Determine specific functional limitation(s) (must be measurable) for client.

Examples of Functional Deficits
Examples of functional deficits may include, **but are not limited to**, the following:

- Inability to hear normal conversational speech
- Inability to hear conversation via the telephone
- Inability to identify, by hearing, environmental sounds necessary for safety (i.e., siren, car horn, doorbell, baby crying, etc.)
- Inability to understand conversational speech (in person or via telephone)
- Inability to hear and/or understand teacher in classroom setting
- Inability to hear and/or understand classmates during class discussion
- Inability to hear/understand co-workers/supervisors during meetings at work
- Inability to read on grade level (as result of auditory processing difficulty)
- Inability to localize sound

Treatment Planning
The treatment plan is developed in conjunction with client/caregiver and medical provider and considers performance in both clinical and natural environments. Treatment should be culturally appropriate. Short- and long-term functional communication goals and specific objectives are determined from assessment. The amount of time, place(s), and professional or lay person(s) involved must be designated. Generalization of skills and strategies is enhanced by extending practice to the natural environment through collaboration among key professionals. Goals and objectives are reviewed periodically to determine appropriateness and relevance.

- Short-term Goals: Improve the overall communication process as defined in functional limitations.
- Long-term Goals: Decrease or eliminate functional deficit.

Note: Rate of improvement varies by client, depending on the severity level, compliance with therapy, and the context in which the client lives and performs activities of daily living.

Discharge/Follow-up
Discharge
The therapy will be discontinued when one of the following criteria is met:

- Client has achieved functional goals and outcomes.
- Client's performance is WNL for chronological age on standardized measures of language, speech, audition, and/or auditory processing (as applicable to the client).
- Client/parent are non-compliant with treatment plan.

At discharge, audiologist will identify indicators for potential follow-up care.

Follow-Up
Readmittance to audiologic (aural) rehabilitation may result from changes in functional status, living situation, school or childcare, caregiver, or personal interests.

4.0 When a Service is Not Covered

OT, PT, Speech/Language-Audiology, and Psychological/Counseling services are not covered when the above medical criteria are not met. Medicaid reimburses for medically necessary services only.

5.0 Requirements for and Limitations on Coverage

5.1 Location of Service

The service must be performed at the location identified on the IFSP/IEP.

5.2 Treatment Services

The initial process for providing treatment, regardless of place of service, consists of the following steps and requirements:

1. All services must be provided according to a written plan. The IEP may be used as treatment plan.
2. The written plan for services must include defined goals for each therapeutic discipline.
3. Each plan must include a specific content, frequency, and length of visits for each therapeutic discipline.
4. A verbal or a written order must be obtained for services* prior to the start of the services. Backdating is not allowed.

   Note: *(*Services are all therapeutic PT, OT, S/L, RT activities **beyond** the entry evaluations. This includes recommendations for specific programs, providers, methods, settings, frequency and intensity of services.)*

   Note: For the school years 2003 through 2007, the order must be obtained prior to services being billed, not before treatment may be rendered.
5. Service providers must review and renew or revise plans and goals no less often than annually, to include obtaining another dated physician signature for the renewed or revised orders. The IEP requirement of parent notification must occur at regular intervals throughout the year, and such notification must detail how progress is sufficient to enable the child to achieve the IEP goals by the end of the year.

   There will be no payment for services rendered more than a year **after** the annual IEP review. The signature date must be the date the physician signs the order. Backdating is not allowed.
6. Faxed orders and faxed signatures are permissible and serve the same purposes for documentation as an original signature on an original form or orders sheet.

All treatment services shall be provided on an individualized basis except for speech/language services that include group speech therapy with a maximum total number of four (4) children per group. The group may contain both non-eligible and Medicaid-eligible recipients. However, only the time spent with the Medicaid-eligible recipient is billable to Medicaid.

5.3 Prior Approval

The prior approval process is deemed met by the IEP process.

5.4 Amount of Service

Only medically necessary services may be reimbursed by Medicaid.

5.5 Other Limitations

A maximum of one assessment service per service type is billable in a six-month period.

Assessment services are billable only for students receiving assessment services prescribed through an IEP. Initial assessments done for the purpose of identification for Special Education Services are only reimbursable from Medicaid after the development of an IEP that lists the service as one being needed by the child. If the assessment does not reveal "medical necessity" for the services, the assessment cannot be billed. Medical necessity criteria outlined in **Section 3.0** of this policy must be met.

Assessment services **do not include** interpretive conferences, educational placement or care planning meetings, mass or individual screenings aimed at selecting children who may have special needs. Time spent for preparation, report writing, processing of claims, documentation regarding billing or service provision, and/or travel is not billable to N.C. Medicaid or to any other payment source, since it is a part of the assessment process which was considered in the determination of the rate per unit of service.

All treatment services shall be provided on an individualized basis as outlined in an IEP with the exception of speech/language services, which include group speech therapy with a maximum total number (i.e., both non-eligible and Medicaid-eligible recipients) of four children per group. Treatment services **do not include** consultation activities, specific objectives involving English as a second language or a treatment plan primarily dealing with maintenance/monitoring activities. Time spent for preparation, processing of claims, documentation regarding billing or service provision, and/or travel is not billable to N.C. Medicaid or to any other payment source, since it is a part of the treatment process which was considered in the determination of the rate per unit of service

6.0 Providers Eligible to Bill for the Service

Local Education Agencies currently enrolled with Medicaid to provide health -related services are eligible to provide this service. Refer to the ***Basic Medicaid Billing Guide*** for information on how to enroll as a Medicaid provider.

6.1 Audiology

- has a valid license issued by the Board of Examiners for Speech and Language Pathologists and Audiologists, and
- has a Certificate of Clinical Competence (CCC) from the American Speech and Hearing Association; or
  - ♦ has completed the equivalent educational requirements and work experience necessary for the CCC, or
  - ♦ has completed the academic program and is acquiring supervised work experience to qualify for the CCC.

6.2 Speech/Language

- has a valid license issued by the Board of Examiners for Speech and Language Pathologists and Audiologists, and
- has a Certificate of Clinical Competence (CCC) from the American Speech and Hearing Association; or
  - ♦ has completed the equivalent educational requirements and work experience necessary for the CCC, or
  - ♦ has completed the academic program and is acquiring supervised work experience to qualify for the CCC.
- Assessment services must be provided by a licensed Speech/Language Pathologist.
- Treatment services may be performed by a Speech/Language Pathologist or a Speech/Language Pathology assistant who works under the supervision of an enrolled licensed practitioner.

6.3 Occupational Therapy

- Assessment services must be provided by a licensed occupational therapist.
- Treatment services must be provided by a licensed occupational therapist or a licensed occupational therapist assistant under the supervision of a licensed occupational therapist.

6.4 Physical Therapy

- Assessment services must be provided by a licensed physical therapist.
- Treatment services must be provided by a licensed physical therapist or a licensed physical therapist assistant under the supervision of a licensed physical therapist.

6.5 Psychological/Counseling Services

- Qualifications of Providers: Minimum qualifications for providing services are licensure as a psychological associate or practicing psychologist by the North Carolina State Board of Examiners of Practicing Psychologists, or certification as a school psychologist by the NC Department of Public Instruction, and Licensed Clinical Social Workers. Licensed Clinical Social Workers and Licensed Psychologists must be able to provide documentation of appropriate training and experience, which qualified them to work with students in an educational setting.

7.0 Additional Requirements

7.1 Documenting Services

Each provider must maintain and allow DMA to access the following documentation for each individual:

- The patient name and Medicaid identification number.
- A copy of the treatment plan. (IEP accepted for LEAs.)
- A copy of the physician's order for treatment services. Date signed must precede treatment dates.

  Note: For the school years 2003 through 2007, please see **Section 5.2, Treatment Services**, items #4 and #5 for additional information.
- Description of services (intervention and outcome/client response) performed and dates of service.
- The duration of service (i.e., length of assessment and/or treatment session **in minutes**).
- The signature of the person providing each service.
- A copy of each test performed or a summary listing all test results, and the written evaluation report.

If group therapy is provided, this should be noted in the provider's documentation for each child receiving services in the group. For providers who provide services to several children simultaneously in a classroom setting, the documentation should reflect this and the duration of services noted in the chart should accurately reflect how much time the provider spent with the child during the day. Such documentation ensures that an adequate audit trail exists and that Medicaid claims are accurate.

Because services provided in schools may be unique and differ from those provided in other settings, documentation to justify medical necessity could be more like progress notes identifying the services provided with an assessment of results and goals for the next treatment. Such documentation does not have to be lengthy and can be accomplished in a couple of sentences. It does, however, have to be clear to a reviewer to support the services billed.

The student's IEP, which is generally only revised once a year, does not serve as documentation sufficient to demonstrate that a service was actually provided, to justify its medical need, or to develop a Medicaid claim. The IEP represents a plan of care showing what services are to be provided and at what frequency. It does not document the provision of these services.

Practitioners/clinicians should keep their own records of each encounter, including the date of treatment, time spent, treatment or therapy methods used, progress achieved, and any additional notes required by the needs of the student. These notes should be signed by the clinician and retained for future review by state or federal Medicaid reviewers. Records must be available to the Division of Medical Assistance (DMA) and its agents and to the U.S. Department of Health and Human Services, and CMS upon request.

Lack of appropriate medical justification may be grounds for denial, reduction or recoupment of reimbursement.

LEAs are responsible for ensuring that salaried and/or contracted personnel adhere to these requirements.

8.0 Billing Guidelines

8.1 What May Be Billed

Assessment services are defined as the administration of an evaluation protocol, involving testing and/or clinical observation as appropriate for chronological or developmental age that results in the generation of a written evaluation report. This protocol may include interviews with family, caregivers, other service providers, and/or teachers as a means to collect assessment data from inventories, surveys, and/or questionnaires.

A maximum of one assessment service per service type is billable in a six-month period. Assessment services are billable only for students receiving assessment services prescribed through an IEP. Initial assessments done for the purpose of identification for Special Education Services are only reimbursable from Medicaid after the development of an IEP that lists the service as one being needed by the child. For example, if a physical therapy evaluation is done as a part of the identification process for Special Education, but physical therapy services are not listed on the IEP as a needed related service, then the evaluation cannot be billed to Medicaid. If the evaluation does not reveal "medical necessity" for the services the evaluation cannot be billed. Medical necessity criteria outlined in section 3.0 of this policy must be met.

Assessment services **do not include** interpretive conferences, educational placement or care planning meetings, mass or individual screenings aimed at selecting children who may have special needs. Time spent for preparation, report writing, processing of claims, documentation regarding billing or service provision, and/or travel is not billable to N.C. Medicaid or to any other payment source, since it is a part of the assessment process which was considered in the determination of the rate per unit of service.

Treatment services are defined as therapeutic procedures, addressing the observed needs of the patient, which are performed and evaluated by the qualified service provider. As one component of the treatment plan, specific objectives involving face-to-face instruction to the family, caregivers, other service providers, and/or teachers **should be included** in order to facilitate carry-over of treatment objectives into the child's daily routine. All treatment services shall be provided on an individualized basis with the exception of speech/language services which includes group speech therapy with a maximum total number (i.e., both non-eligible and Medicaid-eligible recipients) of four children per group.

Treatment services **do not include** consultation activities, specific objectives involving English as a second language or a treatment plan primarily dealing with maintenance/monitoring activities. Time spent for preparation, processing of claims, documentation regarding billing or service provision, and/or travel is not billable to N.C. Medicaid or to any other payment source, since it is a part of the treatment process which was considered in the determination of the rate per unit of service.

8.2 Units of Service

The unit of service is determined by the CPT code used. Event codes may only be billed one unit a day by the same specialty.

Audiology Therapy Assessment

Code	Unit of Service	Code	Unit of Service
92551	(1 unit = 1 test)	92582	(1 unit = 1 test)
92552	(1 unit = 1 test)	92583	(1 unit = 1 test)
92553	(1 unit = 1 test)	92585	(1 unit = 1 test)
92555	(1 unit = 1 test)	92587	(1 unit = 1 test)
92556	(1 unit = 1 test)	92588	(1 unit = 1 test)
92557	(1 unit = 1 test)	92590	(1 unit = 1 test)
92567	(1 unit = 1 test)	92591	(1 unit = 1 test)
92568	(1 unit = 1 test)	92592	(1 unit = 1 test)
92569	(1 unit = 1 test)	92593	(1 unit = 1 test)
92571	(1 unit = 1 test)	92594	(1 unit = 1 test)
92572	(1 unit = 1 test)	92595	(1 unit = 1 test)
92576	(1 unit = 1 test)	92620	(1 unit = 60 min)
92579	(1 unit = 1 test)	92626	(1 unit = 60 min)

92621	Each additional 15 minutes (1 unit = 1 test) must be used with 92620
92627	Each additional 15 minutes (1 unit = 15 minutes) must be used with 92626

Audiology Therapy Treatment

Code	Unit of Service
92507	(1 unit = 1 visit)

Speech/Language Therapy Assessment

Code	Unit of Service
92506	(1 unit = 1 test)
92607	(1 unit = 1 test)
92608	each additional 30 minutes (1 unit = 1 test) must be used with 92607
92551	(1 unit = 1 test)
92610	(1 unit = 1 test)
92612	(1 unit = 1 test)
92626	(1 unit = 60 min)
92627	Each additional 15 minutes (1 unit = 15 minutes) must be used with 92626

Speech/Language Therapy Treatment

Code	Unit of Service	Code	Unit of Service
92507	(1 unit = 1 visit)	92609	(1 unit = 1 visit)
92508	(1 unit = 1 visit)	92630	(1 unit = 1 visit)
92526	(1 unit = 1 visit)	92633	(1 unit = 1 visit)

Occupational Therapy Assessment

Code	Unit of Service	Code	Unit of Service
92610	(1 unit = 1 event)	97003	(1 unit = 1 event)
95831	(1 unit = 1 event)	97004	(1 unit = 1 event)
95832	(1 unit = 1 event)	97750	(1 unit = 15 minutes)
95833	(1 unit = 1 event)	97762	(1 unit = 15 minutes)
95834	(1 unit = 1 event)		

Occupational Therapy Treatment

Code	Unit of Service	Code	Unit of Service
29075	(1 unit = 1 event)	92065	(1 unit = 1 event)
29085	(1 unit = 1 event)	92526	(1 unit = 1 event)
29105	(1 unit = 1 event)	97110	(1 unit = 15 minutes)
29125	(1 unit = 1 event)	97112	(1 unit = 15 minutes)
29126	(1 unit = 1 event)	97116	(1 unit = 15 minutes)
29130	(1 unit = 1 event)	97140	(1 unit = 15 minutes)
29131	(1 unit = 1 event)	97530	(1 unit = 15 minutes)
29240	(1 unit = 1 event)	97533	(1 unit = 15 minutes)
29260	(1 unit = 1 event)	97535	(1 unit = 15 minutes)
29280	(1 unit = 1 event)	97542	(1 unit = 15 minutes)
29530	(1 unit = 1 event)	97760	(1 unit = 15 minutes)
29540	(1 unit = 1 event)	97761	(1 unit = 15 minutes)

Physical Therapy Assessment

Code	Unit of Service	Code	Unit of Service
92610	(1 unit = 1 event)	97001	(1 unit = 1 event)
95831	(1 unit = 1 event)	97002	(1 unit = 1 event)
95832	(1 unit = 1 event)	97750	(1 unit = 15 minutes)
95833	(1 unit = 1 event)	97762	(1 unit = 15 minutes)
95834	(1 unit = 1 event)		

Physical Therapy Treatment

Code	Unit of Service	Code	Unit of Service
29075	(1 unit = 1 event)	29530	(1 unit = 1 event)
29085	(1 unit = 1 event)	29540	(1 unit = 1 event)
29105	(1 unit = 1 event)	92526	(1 unit = 1 event)
29125	(1 unit = 1 event)	97110	(1 unit = 15 minutes)
29126	(1 unit = 1 event)	97112	(1 unit = 15 minutes)
29130	(1 unit = 1 event)	97116	(1 unit = 15 minutes)
29131	(1 unit = 1 event)	97140	(1 unit = 15 minutes)
29240	(1 unit = 1 event)	97530	(1 unit = 15 minutes)
29260	(1 unit = 1 event)	97533	(1 unit = 15 minutes)
29280	(1 unit = 1 event)	97535	(1 unit = 15 minutes)
29405	(1 unit = 1 event)	97542	(1 unit = 15 minutes)
29505	(1 unit = 1 event)	97760	(1 unit = 15 minutes)
29515	(1 unit = 1 event)	97761	(1 unit = 15 minutes)

Psychological/Counseling Services Assessment

Code	Unit of Service	Code	Unit of Service
90801	(1 unit = 1 visit)	96111	(1 unit = 1 hour)
90802	(1 unit = 1 visit)	96116	(1 unit = 1 hour)
96101	(1 unit = 1 hour)	96118	(1 unit = 1 hour)
96110	(1 unit = 1 hour)		

Psychological/Counseling Services Treatment

Code	Unit of Service	Code	Unit of Service
90804	(1 unit = 20–30 minutes)	90812	(1 unit = 45–50 minutes)
90806	(1 unit = 45–50 minutes)	90814	(1 unit = 75-80 minutes)
90808	(1 unit = 75–80 minutes)	90846	(1 unit = 1 visit)
90810	(1 unit = 20-30 minutes)	90853	(1 unit = 1 visit)

Procedures should be billed using the most comprehensive CPT code to describe the service performed, the Correct Coding Initiative (CCI) was developed by and bundles the component procedures of the service into the comprehensive code. Only the comprehensive code is paid. Providers receive an Explanation of Benefits (EOB) denial code if a component code is billed with the comprehensive code. The EOB indicates that the component code cannot be billed in addition to the comprehensive code. Additional information about the CCI can be found online at http://www.hcfa.gov/medlearn/ncci.htm.

8.3 Filing a Claim

Separate CMS-1500 claim forms must be filed for assessment and treatment services, and separate forms must be filed for each type of service provided**.** It should be noted that individual and group speech therapy, being the same type of service, can be listed on the same claim form. All claims should be sent electronically or mailed directly to EDS. Refer to the ***Basic Medicaid Billing Guide*** for general billing information.

Claim Form Type: CMS-1500
Prior Approval for Evaluations: Not required
Prior Approval for Treatments: Not required
Assessment: Billed on one claim form
Treatments: Billed on a separate claim form

CMS-1500 Instructions
Block #1: Type of Coverage
Block #1A: Medicaid Identification Number
Block #2: Patient's Name
Block #3: Patient's Date of Birth
Block #5: Patient's Address/Telephone
Block #10: If applicable to patient's condition
Block #19: Carolina ACCESS referral not required
Block #21: ICD-9-CM diagnosis appropriate for service provided
Block #24A: Date of Service
Block #24B: Place of Service: 03 - School, Head Start, Child Care
Block #24C: Type of Service: Enter 15
Block #24D: See **Section 8.2, Units of Service**
Block #24F: Charges
Block #24G: Enter number of unit(s)
Block #28: Total charges
Block #29: Enter if a third party made payment
Block #30: Balance due
Block #31: Signature of provider
Block #33: Enter provider number

Providers must bill their usual and customary charges. Schools that bill Medicaid for health-related services are only paid the federal share of the Medicaid reimbursement rates.

Procedures should be billed using the most comprehensive CPT code to describe the service performed, the Correct Coding Initiative (CCI) was developed by and bundles the component procedures of the service into the comprehensive code. Only the comprehensive code is paid. Providers receive an Explanation of Benefits (EOB) denial code if a component code is billed with the comprehensive code. The EOB indicates that the component code cannot be billed in addition to the comprehensive code. Additional information about the CCI can be found online at http://www.hcfa.gov/medlearn/ncci.htm.

8.4 Third Party Liability

Medicaid does not pay medical care when a third party covers a recipient, i.e. private insurance or CHAMPUS, who is responsible to make payment for service(s) otherwise covered by Medicaid.

Any Medicaid provider, including LEAs, must agree to first bill the third party before billing Medicaid. It is recognized that federal policy for implementing Part B services of the Individuals with Disabilities Education Act (IDEA) places restrictions on a school to seek third party reimbursement for health related services since Local Education Agencies must provide a free *and* appropriate education. The North Carolina Department of Public Instruction, Division of Exceptional Children's Services is advising that LEAs not bill Medicaid when the recipient's Medicaid identification card indicates the existence of third party insurance coverage. This will ensure that schools remain in compliance with IDEA requirements.

If the LEA obtains evidence that the existing health insurance does not cover IEP required health services, Medicaid may be billed for those services. The 'free and appropriate education" requirements of the North Carolina Department of Public Instruction are satisfied if pertinent information regarding the contact with the third party carrier is recorded

Refer to ***Basic Medicaid Billing Guide*** for additional information.

8.5 Certification of Non Federal Match

Schools that bill Medicaid for health-related services are only paid the federal share of the Medicaid reimbursement rates. The federal share equals about 2/3 of the total Medicaid reimbursement rate. The state portion of the Medicaid rate is not paid to the schools. Schools are responsible for "matching" the federal payment with state funds already in their budgets. This involves identifying what state funds in the school budget are being designated to match the federal Medicaid payment received by the school. Each Local Education Agency must certify the availability of the matching non-federal share of service payments. This certification is required on a quarterly basis and is completed in accordance with instructions provided to each enrolled Local Education Agency by the Department of Health and Human Services, Division of Medical Assistance.

The Federal Financial Participation (FFP) rate changes annually on October 1st of each year.

Refer to **Attachment A** for a copy of the **Certification of Non-Federal Match form** and instructions for completing the form.

9.0 Policy Implementation/Revision Information

Original Effective Date: August 1, 2003

Revision Information:

Date	Section Revised	Change
7/01/05	Section 5.2, Treatment Services # 4 Section 7.1, Documenting Services	Extended through school year 2006 that the order must be obtained prior to services being billed, not before treatment rendered.
1/1/05	Section 8.2, Audiology Assessment	CPT code92589 was end-dated and replaced with 92620 and 92621
7/01/04	Section 1.5, Psychological/Counseling Services treatment services	Sociodrama and social skills training changed to individual interactive psychotherapy using play equipment, physical devices, language interpreter or other mechanisms of non verbal communication and sensory integrative therapy
7/01/04	Section 5.2, Treatment Services # 5	Requirement for six month plan review and physician's order changed to annual review and order provided that parent notification occurs regularly and details how goals will be attained by year-end.
7/01/04	Section 5.2, Treatment Services # 4 Section 7.1, Documenting Services	Extended through school year 2005 that the order must be obtained prior to services being billed, not before treatment rendered.
10/01/03	Appendix A	The mailing address for the form was changed.
10/01/03	Section 3.3.1, Audiology Therapy (aural rehabilitation) Practice Guidelines	Section 3.3.1 was added to address audiology therapy practice guidelines.

Revision Information, continued

Date	Section Revised	Change
10/1/03	3.3, Speech/Language-Audiology Therapy	This section was expanded to include Audiology Therapy; the title of the section was changed to Speech/Language-Audiology Therapy. Augmentative and Alternative Communication (AAC) standards for treatment were also added.
7/1/04	Section 5.5, Other Limitations Section 8.1, Billing Guidelines	Added reimbursement for initial assessments if the service is an identified need in the IEP
7/1/04	Entire policy	Psychological changed to Psychological/Counseling
7/1/04	Section 6.1, Audiology Section 6.2, Speech/Language	Changed provider qualifications to allow CCC equivalency
12/1/03	Section 5.0	The section was renamed from Policy Guidelines to Requirements for and Limitations on Coverage.
9/1/05	Section 2.0	A special provision related to EPSDT was added.
12/1/05	Section 2.3	The web address for DMA's EDPST policy instructions was added to this section.
12/1/05	Section 8.3	The Place of Service code was converted to 03.
1/1/06	Section 8.2	CPT procedure code 95210 was end-dated and replaced with 92626, 92627, 92630 and 92633; 97504 was end-dated and replaced with 97760; 97520 was end-dated and replaced with 97761; 97703 was end-dated and replaced with 97762; 96100 was end-dated and replaced with 96101; 96115 was end-dated and replaced with 96116; and 96117 was end-dated and replaced with 96118.
6/1/06	Section 5.2, Treatment Services # 4 Section 7.1, Documenting Services	Extended through school year 2007 that the order must be obtained prior to services being billed, not before treatment rendered.
6/1/06	Section 8.2	CPT procedure codes 92626 and 92627 were deleted from the list of codes for Speech/Language Treatment and added to the list of codes for Speech/Language Assessment and Audiology Assessment.
7/1/06	Attachment A	The Certification of Non-Federal Match Form was replaced with a new version of the form.
10/1/06	Attachment A	The Certification of Non-Federal Match Form was replaced with a new version of the form.

Attachment A

Division of Medical Assistance
Local Education Agencies

Effective Date October 1, 2004
Revised Date: September 28. 2006

Certification of Non-Federal Match Form
(To be used to certify Fee-For-Services)

INSTRUCTIONS: Complete items 1 through 4 below, sign and date, and return the form to the address at the top of the second page. Please refer to your Remittance Advice - Total Paid Claims section when completing this form.

- -

SCHOOL SYSTEM ____

MEDICAID PROVIDER NUMBER ________________________ QUARTER: __________________________
(MO/YY – MO/YY)

1. TOTAL MEDICAID ALLOWABLE $ ____
*Note-This amount should come from the RA – Total Paid Claims- in the Payable Charge Column

2. TOTAL MEDICAID RECEIPTS
(Amount Received - FEDERAL SHARE ONLY) $ ____
* Note – This amount should come from the RA – Paid Amt. Column

3. NON FEDERAL MATCH REQUIRED = (#1 – #2)
(State Funds that the school must Identify) $ ____

4. NON FEDERAL MATCH FUNDS provided by school. Designate the source and amount of funds in your school budget that you are using to match the federal funds received from Medicaid. The total amount of the state funds that you identify must equal the amount shown in item #3 above.

SOURCE	**AMOUNT**
______________________	**$** ______________________
______________________	**$** ______________________
______________________	$ ______________________

I CERTIFY THAT, TO THE BEST OF MY KNOWLEDGE, THE NON-FEDERAL MATCH IDENTIFIED IN #3 ABOVE, FOR THE QUARTER ENDING _______________ REPRESENTS ACTUAL EXPENDITURES ACCUMULATED. THE CERTIFIED AMOUNT DOES NOT DUPLICATE ANY FEDERAL CLAIMS FOR REIMBURSEMENT, NOR ARE THE FUNDS USED TO MATCH OTHER FEDERAL FUNDS, UNLESS EXPRESSLY ALLOWED BY FEDERAL REGULATION.

FOR ANY QUARTER IN WHICH THE SCHOOL SYSTEM IS OR WILL BE SEEKING REIMBURSEMENT FOR ANY MEDICAID ADMINISTRATIVE ACTIVITIES THAT ARE RELATED TO THE DELIVERY OR COORDINATION OF MEDICAID SCREENING, DIAGNOSIS, OR TREATMENT SERVICES, I CERTIFY THAT THE SCHOOL SYSTEM HAS A MEDICAID REMITTANCE ADVICE ON FILE DOCUMENTING THAT THERE WERE MEDICAID ALLOWABLE PAID CLAIMS FOR SERVICES THAT WERE ACTUALLY DELIVERED TO CHILDREN DURING THAT QUARTER.

CERTIFICATION OF FUNDS BY __________________________________ **DATE:** _______________
Signature of School Fiscal Budget Officer

Name (Please Print) ______________________________________

Title ______________________________________

RETURN THIS COMPLETED FORM TO:

DHHS – Division of Medical Assistance
Attention: Budget Management
2501 Mail Service Center
Raleigh, NC 27699-2501

The Local Educational Agency (LEA) may bill Medicaid for health related services and are eligible to be reimbursed the federal share only of the Medicaid allowed amount. The LEA's are responsible for "matching" the federal payment with state funds already in their budgets. This involves identifying what state funds in the school budget are being designated to match the federal Medicaid payment received by the school.

Each LEA must certify the availability of the matching non-federal share of service payments. All LEA's being reimbursed for Fee for Services (FFS) must sign and submit a "Certification of Non-Federal Match Form" to the Division of Medical Assistance to certify Fee for Service. This form should be submitted to DMA for expenditures incurred in a calendar quarter (Ex: Jan-Mar, April-Jun, July-Sept, Oct-Dec).

Procedure for Completing the Fee for Service Certification Form

1. **Total Medicaid Allowable** - All costs that Medicaid will allow as certifiable FFS expenditures. This amount is shown in the summary page of "Total Paid Claims" on the Remittance Advice (RA) and should be equal to the total in the column marked "Payable Charge".

2. **Total Medicaid Receipts** - The amount of Federal Funds received in support of the FFS program. This amount is shown in the summary page of "Total Paid Claims" on the Remittance Advice (RA) and should be equal to the total in the column marked "Paid Amount".

3. **Non-Federal Match Required** – These are the state funds that the LEA must identify. The amount is equal to the Total Medicaid expenses allowable (#1) less the Total Medicaid Receipts (#2).

4. **Non-Federal Match Funds –** Designate the source and the amount of funds in your school budget that you are using to match the federal funds received by Medicaid. This amount should be equal to the amount in #3.

5. The School's Fiscal Budget Officer must sign and date the form, certifying the accuracy and completeness of the amounts listed.